2016 Employee Benefits Overview

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Welcome to the City of Newport Beach

The City of Newport Beach takes pride in offering a benefits program that provides flexibility for the diverse and changing needs of our employees. We are pleased to provide you with the 2016 Employee Benefits Overview for eligible employees of the City of Newport Beach. Please review this guide carefully and retain this guide for the calendar year 2016 as an easy reference to your benefit plan offerings.

The City of Newport Beach offers you and your eligible dependents the following benefits:

- Medical, Dental and Vision Insurance
- Basic Life / Accidental Death & Dismemberment (AD&D) Insurance
- Voluntary Life / Accidental Death & Dismemberment (AD&D) Insurance
- Long-Term Disability (LTD) Insurance
- Short-Term Disability (STD) Insurance
- Employee Assistance Program (EAP)
- Flexible Spending Accounts
- Deferred Compensation

Summary

The information in this booklet is a general outline of the benefits offered under the City of Newport Beach benefits program. Specific details and plan limitations are provided in the Summary Plan Description (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail.

If you have any questions or need additional information, please contact Human Resources at (949) 644-3300

Web Address: www.newportbeachca.gov

Open Enrollment Period

This booklet will give you information about the benefits which are available to you. Please read the information carefully. To help you make important decisions about your benefits, Human Resources is available to answer any questions you may have.

Open Enrollment

Beginning on Monday, September 14, 2015 and lasting through Friday, October 9, 2015, all plan participants will be eligible to participate in the annual Open Enrollment period. During Open Enrollment, you will be able to change group medical plans and add/or drop dependent coverage.

Your new plan benefits will be effective January 1, 2016 and will run through December 31, 2016. In order to ensure a smooth implementation, you must make your changes through the Employee Assistance Center (EAC) no later than midnight on October 9, 2015. The opt-out waivers are due by 4:30pm on October 9, 2015.

Please call Human Resources if you have any questions at (949) 644-3300.

Helpful Hints

Read through this guide to familiarize yourself with what decisions you have to make. Think about your current benefit plans. Are they still working for you? Have you experienced any changes or do you anticipate any that might make a different plan more suitable?

Gather additional information. Use the websites and phone numbers on page 36 to see which doctors and other healthcare providers you can use under the different plan choices. If you have dependents on your plan that live out of state, check on provisions for coverage of members away from home.

Plan	Benefit Changes
CalPERS Medical	• CalPERS has increased its number of acupuncture and chiropractic services (combined) from 15 to 20 annual visits (PPO's only). Employees enrolled in a PORAC plan will pay $20 for up to 20 visits, 10% for out-of-network acupuncture services and $35 per visit for out-of-network chiropractic services.
Dental	• NEW Carrier - Cigna
Vision	• NEW Carrier - MES (Medical Eye Services)
Life and Disability	• NEW Carrier - Cigna

Dependent Eligibility Verification

All employees adding/removing dependents must submit documentation to verify their dependent's eligibility and/or Qualifying Life Event. The following chart is an easy guide to what documents must be submitted along with the Health Enrollment/Change form.

	Enrollment Form Required	Marriage Certificate Required	State of California Domestic Partner (DP) Registration	Birth Certificate/ Certificate of Adoption Required	Social Security Number
Employee only	•				
Employee & Spouse	•	•			•
Employee & Domestic Partner (DP)	•		•		•
Employee & Children	•			•	•
Employee, Spouse/DP & Children	•	•	•	•	•

You are responsible for ensuring that the health enrollment information about you and your family members is accurate, and for reporting any changes in a timely manner. If you fail to maintain current and accurate health enrollment information, you may be liable for the reimbursement of health premiums or health care services incurred during the entire ineligibility period.

For example, if your divorce or dissolution occurred in 2013, yet you did not report it until 2015, your former spouse or domestic partner will be retroactively canceled from coverage effective the first of the month following the divorce or dissolution.

On page 6, you will find a detailed list of Qualifying Life Events, which must be reported to the HR Department so we can make the appropriate change to your health coverage. All Qualifying Life Event changes must be made within 60 days from the date of the event. Proper documentation is required, such as a copy of the marriage/domestic partnership certificate, birth/adoption certificate, or divorce/ dissolution of domestic partnership decree.

For further clarification, please contact Human Resources at (949) 644-3300.

When You Can Make Changes

Other than during the annual Open Enrollment period, you may not change your coverage unless you experience a qualifying life event.

Qualifying life events include:

- Change in legal marital status, including marriage, divorce, legal separation, annulment, dissolution of domestic partnership, and death of a spouse.
- Change in number of dependents, including birth, adoption, placement for adoption, or death of a dependent child.
- Change in employment status, including the start or termination of employment by you, your spouse, or your dependent child.
- Change in work schedule, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits.
- Change in a child's dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them.
- Change in your health coverage or your spouse's coverage attributable to your spouse's employment.
- Change in an individual's eligibility for Medicare or Medicaid.
- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child or dependent foster child.
- An event that is a qualifying life event under the Health Insurance Portability and Accountability Act (HIPAA), including acquisition of a new dependent or spouse or loss of coverage under another health insurance policy or plan if the coverage is terminated because of:
    - Voluntary or involuntary termination of employment or reduction in hours of employment or death, divorce, or legal separation;
    - Termination of employer contributions toward the other coverage, OR if the other coverage was COBRA Continuation Coverage, exhaustion of the coverage.

Important—Two rules apply to making changes to your benefits during the year:

- Any changes you make must be consistent with the change in status, AND
- You must make the changes within 60 days of the date the event occurs.

If you make mid-year changes to your insurance (adding/dropping dependents), contact Human Resources and provide supporting documents within 60 days of the change in status.

City Contributions

Cafeteria & Medical Allowance Contributions				
Association/Bargaining Unit	Hired on or BEFORE December 31, 2012		Hired on or AFTER January 1, 2013	
	Contribution	Opt-Out Amount	Contribution	Opt-Out Amount
CEA, K&M, League & Prof/Tech	$1,674.00	$1,249.00	$1,674.00	$600.00
FA & FMA	$1,399.00	$1,149.00	$1,399.00	$1,149.00
LMA	$1,649.00	$1,000.00	$1,649.00	$1,000.00
PA	$1,649.00	$1,000.00	$1,649.00	$1,000.00
PMA*	$1,674.00	$1,000.00	$1,674.00	$1,000.00

*Pending adoption of MOU

Health Premium Rates

Monthly Health and Welfare Program Insurance Premium Rates 1/01/2016 through 12/31/2016			
MEDICAL PLANS Other Southern California Region	Single	2-Party	Family
HMO's			
Anthem HMO Select	$634.75	$1,269.50	$1,650.35
Anthem HMO Traditional	$710.79	$1,421.58	$1,848.05
Blue Shield - Access+HMO	$654.87	$1,309.74	$1,702.66
Blue Shield - NetValue HMO	$666.35	$1,332.70	$1,732.51
Health Net Salud y Mas HMO	$535.98	$1,071.96	$1,393.55
Health Net SmartCare HMO	$596.98	$1,193.96	$1,552.15
Kaiser Permanente HMO	$605.05	$1,210.10	$1,573.13
Sharp HMO (only available in San Diego County)	$561.34	$1,122.68	$1,459.48
UnitedHealthcare HMO	$493.99	$987.98	$1,284.37
PPO's			
PERS Choice	$683.71	$1,367.42	$1,777.65
PERS Select	$625.20	$1,250.40	$1,625.52
PERS Care	$761.50	$1,523.00	$1,979.90
PORAC*	$699.00	$1,399.00	$1,789.00
MEDICAL PLANS Los Angeles Region	Single	2-Party	Family
HMO's			
Anthem HMO Select	$543.47	$1,086.94	$1,413.02
Anthem HMO Traditional	$610.64	$1,221.28	$1,587.66
Blue Shield - Access+HMO	$566.53	$1,133.06	$1,472.98
Blue Shield - NetValue HMO	$576.46	$1,152.92	$1,498.80
Health Net Salud y Mas HMO	$466.11	$932.22	$1,211.89
Health Net SmartCare HMO	$585.39	$1,170.78	$1,522.01
Kaiser Permanente HMO	$543.83	$1,087.66	$1,413.96
UnitedHealthcare HMO	$492.24	$984.48	$1,279.82
PPO's			
PERS Choice	$598.75	$1,197.50	$1,556.75
PERS Select	$547.55	$1,095.10	$1,423.63
PERS Care	$666.91	$1,333.82	$1,733.97
PORAC*	$699.00	$1,399.00	$1,789.00

*Available only to members of Police Officer's Research Association of California

Dental & Vision Premium Rates

Monthly Health and Welfare Program Insurance Premium Rates 1/01/2016 through 12/31/2016			
CIGNA DENTAL	Employee Only	Employee + 1	Employee + 2 or More
PPO	$51.68	$105.18	$154.60
DHMO	$12.82	$23.07	$34.73

MES VISION	Employee Only	Employee + 1	Employee + 2 or More
MES PPO	$7.30	$13.99	$19.99

Medical Benefits

The goal of the City of Newport Beach is to provide you with affordable, quality health care benefits. Our medical benefits are designed to help maintain wellness and protect you and your family from major financial hardship in the event of illness or injury. The City offers a choice of medical plans through the CalPERS Medical Program.

Anthem Blue Cross, Blue Shield, Health Net, Kaiser Permanente and UnitedHealthcare

Health Maintenance Organization (HMO)

Under the HMO plans, most services and medicines are covered with a small copayment. You select a Primary Care Physician (PCP) to coordinate your care. You have a choice between the CalPERS Anthem Blue Cross Select, Anthem Blue Cross Traditional, Blue Shield Access+, Blue Shield Net Value, Health Net SmartCare, Kaiser Permanente and UnitedHealthcare Alliance HMO plans.

Anthem Blue Cross

Preferred Provider Organization (PPO)

The Anthem Blue Cross PPO plan is designed to provide choice, flexibility and value. The PPO plan is a managed care organization of medical doctors, hospitals, and other health care providers who have contracted with the Anthem Blue Cross to provide health care at reduced rates to you. Participants have a choice of using network providers or going directly to any other physician (non-network provider) without a referral. There is an annual deductible to meet before benefits apply. You are also responsible for a certain percentage of the charges (coinsurance), and the plan pays the balance up to the agreed upon amount. You have a choice between the CalPERS Anthem Blue Cross—PERS Choice, PERS Select, PERSCare, and PORAC plans.

In order to ensure a smooth implementation, you must make your changes through the Employee Assistance Center (EAC) no later than midnight on October 9, 2015. The opt-out waivers are due by 4:30pm on October 9, 2015.

Why Would I Choose the PPO Plan?	Why Would I Not Choose the PPO Plan?
• You have a doctor you like and you would like to keep this doctor. • You want to see specialists and other providers without having to first get a referral and/or pre-approval. • You want the freedom to see providers who are not in the network. • You are confident that you can manage your own care. • You do not want a primary care doctor.	• You don't want the extra responsibility of managing your own care. • PPOs are not as closely regulated by the government as HMOs. • You do not want to pay the higher costs of a PPO. • You do not want to get bills from providers.

CalPERS HMO Medical Plan Options

Medical Benefits	Anthem, Blue Shield, Health Net, Sharp, and United HealthCare
Calendar Year Deductible	N/A
Annual Out-of-Pocket Maximum (Excluding Pharmacy)	$1,500 individual / $3,000 family
Physician Office Visit	$15 / visit
Preventive Care	No charge
Diagnostic Lab and X-Ray	No charge
Hospitalization	
Inpatient	No charge
Outpatient	No charge
Emergency Room Services & Supplies	$50 / visit (waived if admitted)
Urgent Care	$15 copay
Chiropractic and Acupuncture (20 visits per calendar year combined benefit)	$15 / visit
Durable Medical Equipment	No charge
Mental Health/Substance Abuse	
Inpatient	No charge
Outpatient	$15 copay
Prescription Rx: Retail (Up to 30 day supply)	
Generic Rx	$5 copay
Brand Name Rx	$20 copay
Non-Formulary Rx	$50 copay
Prescription Rx: Mail Order (Up to 90 day supply)	
Generic Rx	$10 copay
Brand Name Rx	$40 copay
Non-Formulary	$100 copay

1. You must choose a Primary Care Physician (PCP) from the contracting/participating network.

Note: This is a brief summary of benefits. Please refer to the Evidence of Coverage or Summary Plan Description for a detailed list of the benefits that are covered on this plan.

CalPERS HMO Medical Plan Options

Medical Benefits	Kaiser Permanente HMO
Calendar Year Deductible	N/A
Annual Out-of-Pocket Maximum (Excluding Pharmacy)	$1,500 individual / $3,000 family
Physician Office Visit	$15 / visit
Preventive Care	No charge
Diagnostic Lab and X-Ray	No charge
Hospitalization	
Inpatient	No charge
Outpatient	$15 copay
Emergency Room Services & Supplies	$50 / visit (waived if admitted)
Urgent Care	$15 copay
Chiropractic and Acupuncture (20 visits per calendar year combined benefit)	$15 / visit
Durable Medical Equipment	No charge
Mental Health/Substance Abuse	
Inpatient	No charge
Outpatient	$15 copay
Prescription Rx: Retail (Up to 30 day supply)	
Generic Rx	$5 copay
Brand Name Rx	$20 copay
Non-Formulary Rx	
Prescription Rx: Mail Order (Up to 90 day supply)	
Generic Rx	$10 copay
Brand Name Rx	$40 copay
Non-Formulary	

1. You must choose a Primary Care Physician (PCP) from the contracting/participating network.

Note: This is a brief summary of benefits. Please refer to the Evidence of Coverage or Summary Plan Description for a detailed list of the benefits that are covered on this plan.

CalPERS PPO Medical Plan Options - Anthem Blue Cross

Medical Benefits	PERS Select PPO	
	Network	Non-Network*
Calendar Year Deductible	$500 Individual / $1,000 Family	
Annual Out-of-Pocket Maximum (Excluding Pharmacy)	$3,000 Individual / $6,000 Family	None
Physician Office Visit	$20 / Visit (deductible waived)	40%
Preventive Care	No Charge (deductible waived)	40%
Diagnostic Lab and X-Ray	20% of Negotiated Fee	40%
Hospitalization Inpatient/Outpatient	20%-30% of Negotiated Fee	40%
Emergency Room Services & Supplies	$50 copay, then 20% of Negotiated Fee (copay waived if admitted)	
Urgent Care	$20 copay (deductible waived)	40%
Chiropractic and Acupuncture (20 visits per calendar year combined benefit)	$15 / Visit (deductible waived)	40%
Durable Medical Equipment	20% of Negotiated Fee (pre-certification required for equipment)	40% (pre-certification required for equipment)
Mental Health/Substance Abuse Inpatient/Outpatient	20%-30% of Negotiated Fee	40%
Prescription Rx: Retail (Up to 30 day supply)		
Generic Rx	$5 copay	$5 copay**
Brand Name Rx	$20 copay	$20 copay**
Non-Formulary Rx	$50 copay	$50 copay**
Prescription Rx: Mail Order (Up to 90 day supply)		
Generic Rx	$10 copay	$10 copay**
Brand Name Rx	$40 copay	$40 copay**
Non-Formulary	$100 copay	$100 copay**

*Non-network benefits based upon Anthem Blue Cross' Reasonable and Customary (R&C) charges.

**When filling prescriptions at non-participating pharmacies, you are required to pay the listed dollar copayment (if applicable), plus 50% of the prescription drug's Maximum Allowed Amount (MAA). You are also obligated to pay any amounts the pharmacy charges in excess of the MAA.

Note: This is a brief summary of benefits. Please refer to the Evidence of Coverage or Summary Plan Description for a detailed list of the benefits that are covered on this plan.

CalPERS PPO Medical Plan Options - Anthem Blue Cross

Medical Benefits	PERS Choice PPO	
	Network	Non-Network*
Calendar Year Deductible	$500 Individual / $1,000 Family	
Annual Out-of-Pocket Maximum (Excluding Pharmacy)	$3,000 Individual / $6,000 Family	None
Physician Office Visit	$20 / Visit (deductible waived)	40%
Preventive Care	No Charge (deductible waived)	40%
Diagnostic Lab and X-Ray	20% of Negotiated Fee	40%
Hospitalization Inpatient/Outpatient	20% of Negotiated Fee	40%
Emergency Room Services & Supplies	$50 copay, then 20% of Negotiated Fee (copay waived if admitted)	
Urgent Care	$20 copay (deductible waived)	40%
Chiropractic and Acupuncture (20 visits per calendar year combined benefit)	$15 / Visit (deductible waived)	40%
Durable Medical Equipment	20% of Negotiated Fee (pre-certification required for equipment)	40% (pre-certification required for equipment)
Mental Health/Substance Abuse Inpatient/Outpatient	20% of Negotiated Fee	40%
Prescription Rx: Retail (Up to 30 day supply)		
Generic Rx	$5 copay	$5 copay**
Brand Name Rx	$20 copay	$20 copay**
Non-Formulary Rx	$50 copay	$50 copay**
Prescription Rx: Mail Order (Up to 90 day supply)		
Generic Rx	$10 copay	$10 copay**
Brand Name Rx	$40 copay	$40 copay**
Non-Formulary	$100 copay	$100 copay**

*Non-network benefits based upon Anthem Blue Cross' Reasonable and Customary (R&C) charges.

**When filling prescriptions at non-participating pharmacies, you are required to pay the listed dollar copayment (if applicable), plus 50% of the prescription drug's Maximum Allowed Amount (MAA). You are also obligated to pay any amounts the pharmacy charges in excess of the MAA.

Note: This is a brief summary of benefits. Please refer to the Evidence of Coverage or Summary Plan Description for a detailed list of the benefits that are covered on this plan.

CalPERS PPO Medical Plan Options - Anthem Blue Cross

Medical Benefits	PORAC	
	Network	Non-Network*
Calendar Year Deductible	$300 Individual / $900 Family	$600 Individual / $1,800 Family
Annual Out-of-Pocket Maximum (Excluding Pharmacy)	$3,300 Individual / $6,600 Family	None
Physician Office Visit	$20 / Visit (deductible waived)	10%
Preventive Care ($500 combined maximum per calendar year)	No Charge (deductible waived)	No Charge (deductible waived)
Diagnostic Lab and X-Ray	10% of Negotiated Fee	10%
Hospitalization Inpatient/Outpatient	10% of Negotiated Fee	10%
Emergency Room Services & Supplies	10% of Negotiated Fee	
Urgent Care	10% of Negotiated Fee	
Chiropractic	$20 copay, up to 20 visits	$35 copay
Acupuncture	$20 copay (10% for all other services)	10%
Durable Medical Equipment	20% of Negotiated Fee	
Mental Health/Substance Abuse Inpatient/Outpatient	10% of Negotiated Fee	10%
Prescription Rx: Retail (Up to 30 day supply)		
Generic Rx	$10 copay	$10 copay**
Brand Name Rx	$25 copay	$25 copay**
Non-Formulary Rx	$45 copay	$45 copay**
Prescription Rx: Mail Order (Up to 90 day supply)		
Generic Rx	$20 copay	n/a
Brand Name Rx	$40 copay	n/a
Non-Formulary	$75 copay	n/a

*Non-network benefits based upon Anthem Blue Cross' Reasonable and Customary (R&C) charges.

**When filling prescriptions at non-participating pharmacies, you are required to pay the listed dollar copayment (if applicable), plus 50% of the prescription drug's Maximum Allowed Amount (MAA). You are also obligated to pay any amounts the pharmacy charges in excess of the MAA.

Note: This is a brief summary of benefits. Please refer to the Evidence of Coverage or Summary Plan Description for a detailed list of the benefits that are covered on this plan.

CalPERS PPO Medical Plan Options - Anthem Blue Cross

Medical Benefits	PERSCare PPO	
	Network	Non-Network*
Calendar Year Deductible	$500 Individual / $1,000 Family	
Annual Out-of-Pocket Maximum (Excluding Pharmacy)	$2,000 Individual / $4,000 Family	None
Physician Office Visit	$20 / Visit (deductible waived)	40%
Preventive Care	No Charge (deductible waived)	40%
Diagnostic Lab and X-Ray	10% of Negotiated Fee	40%
Hospitalization Inpatient	$250 per admit deductible, then 10%	$250 per admit deductible, then 40%
Outpatient	10% of Negotiated Fee	40%
Emergency Room Services & Supplies	$50 copay, then 10% of Negotiated Fee (copay waived if admitted)	
Urgent Care	$20 copay (deductible waived)	40%
Chiropractic and Acupuncture (20 visits per calendar year combined benefit)	$15 / Visit (deductible waived)	40%
Durable Medical Equipment	10% of Negotiated Fee (pre-certification required for equipment $1,000 or more)	40% (pre-certification required for equipment $1,000 or more)
Mental Health/Substance Abuse Inpatient	$250 per admit deductible, then 10%	$250 per admit deductible, then 40%
Outpatient	10% of Negotiated Fee	40%
Prescription Rx: Retail (Up to 30 day supply)		
Generic Rx	$5 copay	$5 copay**
Brand Name Rx	$20 copay	$20 copay**
Non-Formulary Rx	$50 copay	$50 copay**
Prescription Rx: Mail Order (Up to 90 day supply)		
Generic Rx	$10 copay	$10 copay**
Brand Name Rx	$40 copay	$40 copay**
Non-Formulary	$100 copay	$100 copay**

*Non-network benefits based upon Anthem Blue Cross' Reasonable and Customary (R&C) charges.

**When filling prescriptions at non-participating pharmacies, you are required to pay the listed dollar copayment (if applicable), plus 50% of the prescription drug's Maximum Allowed Amount (MAA). You are also obligated to pay any amounts the pharmacy charges in excess of the MAA.

Note: This is a brief summary of benefits. Please refer to the Evidence of Coverage or Summary Plan Description for a detailed list of the benefits that are covered on this plan.

Dental DHMO Plan (Administered by Cigna) - **NEW!**

Under the Cigna DHMO plan, dental services are provided through the Cigna network. When you enroll, you select a contract dentist to provide services. The Cigna network consists of private practice dental facilities that have been carefully screened for quality.

Cigna DHMO	
Dental Benefits*	**Member Pays**
Diagnostic and Preventive Oral Evaluation	No Cost
Prophylaxis Cleaning - 2 per calendar year	No Cost
X-rays (Intraoral) - 1 every 3 years	No Cost
Restorative Amalgam Filing (1-4 Surfaces)	No Cost
Composite Filling Anterior (1-4 Surfaces)	No Cost
Periodontics Gingivectomy—(Per Quadrant)	$70
Osseous Surgery	$205
Endodontics Pulp Cap	No Cost
Therapeutic Pulpotomy	$3
Root Canal Therapy - (anterior, bicuspid, molar)	$50—$135
Prosthodontics Immediate—Upper or Lower	$125[1]
Complete—Upper or Lower	$120[1]
Crown and Bridge Crown—Porcelain/Ceramic Substrate	$210[2]
Crown—Porcelain Fused to High Noble Metal	$100[2]
Oral Surgery Extractions—Impacted tooth: Soft tissue	$25
Extractions—Impacted tooth: Partial bony	$45
Orthodontics Child to Age 19 Member over Age 19	$1,100 $1,600

*Limitations may apply for some benefits; some services may be excluded. Please refer to the Evidence of Coverage or Summary Plan Description for a list of benefit limitations and exclusions. See the "Description of Benefits and Copayments" for a full list of benefits.

[1] Characterization is considered an upgrade with maximum additional charge to the member of $200 per denture.

[2] No more than $150 per tooth for any noble metal alloys, high noble metal alloys, titanium, or titanium alloys. No more than $75 per tooth for any porcelain fused to metal. Porcelain/ceramic substrate crowns on molar teeth are not covered.

Note: This is a brief summary of benefits. Please refer to the Evidence of Coverage or Summary Plan Description for a detailed list of the benefits that are covered on this plan.

Dental DPPO Plan (Administered by Cigna) - **NEW!**

Under the Cigna Preferred Provider Organization (PPO) plan, dental services are provided through the Cigna PPO network. However, you can choose to visit any dentist in any location inside or outside of the Cigna network. How much you pay for dental services depends on whether you choose a participating Cigna dentist. If you choose a non-participating dentist, you pay the difference between the amount the dentist receives from Cigna (the "allowable amount") and the dentist's charges.

Cigna DPPO		
Dental Benefits*	**Cigna Advantage and DPPO Network**	**Out-of-Network****
Calendar Year Maximum	$2,000 per member	
Calendar Year Deductible Individual / Family	None	$50 /$150
Diagnostic and Preventive Oral Examinations X-Rays Teeth Cleaning Fluoride Treatment Space Maintainers (non-ortho treatment)	100%	100% (deductible waived)
Basic Services Filings Sealants Periodontics (Gum disease) Endodontics (Root Canal) Extractions & Other Simple Oral Surgery	90%	80%
Major Services Restorative - Inlays/Onlays and Crowns Dentures Bridges	60%	50%
Implants	60%	50%
Orthodontia Adults and Children	50% $2,000 lifetime max	

*Limitations may apply for some benefits; some services may be excluded. Please refer to your Evidence of Coverage or Summary Plan Description for a list of benefit limitations and exclusions. See the "Description of Benefits and Copayments" for a full list of benefits.

** Non-Cigna Dentists are reimbursed at the lesser of the submitted charge or the fee that satisfies the majority of dentists in the same geographical area with the same training (90th percentile of Usual, Customary and Reasonable)

Note: This is a brief summary of benefits. Please refer to the Evidence of Coverage or Summary Plan Description for a detailed list of the benefits that are covered on this plan.

Vision Benefits (Administered by MES) - **NEW!**

You are eligible for vision coverage through MES Vision. MES provides coverage for eye exams and materials, such as lenses and frames.

Plan Benefits	MES Network	Out-of-Network
Exam	$10 copay	Plan pays up to $40
Single Lenses	Covered in Full	Plan pays up to $30
Bifocal Lenses	Covered in Full	Plan pays up to $50
Trifocal Lenses	Covered in Full	Plan pays up to $65
Contact Lenses**		
Elective	$105 Allowance	Plan pays up to $105
Medically Necessary	Covered in Full*	Plan pays up to $250
Frames	$100 Allowance	Plan pays up to $40
Benefit Frequency		
Exam	Every 12 Months	
Lenses and Contacts**	Every 12 Months	
Frames	Every 12 Months	

*Subject to Copayment
** In lieu of frames

You may receive benefits when using non-MES providers by submitting your claims directly to MES. Reimbursements will be made as indicated in the out-of-network schedule above. Find a MES network doctor at www.mesvision.com or call (800) 877-6372.

Note: This is a brief summary of benefits. Please refer to the Evidence of Coverage or Summary Plan Description for a detailed list of the benefits that are covered on this plan.

Life and AD&D Benefits (Administered by Cigna) - NEW!

Basic Life and AD&D Insurance

Basic Life/AD&D	
Employee Benefit	1 times annual Earnings, rounded to the next higher $1,000, subject to a maximum of $50,000

Voluntary Life and AD&D Insurance

Voluntary Life/AD&D	
Employee Coverage	Maximum of $500,000 in $10,000 increments with no minimum benefit Guaranteed Issue: $40,000
Spouse Coverage	Maximum of $500,000 in $10,000 increments with no minimum benefit subject to 100% of the employee's amount Guaranteed Issue: $40,000
Child(ren) Coverage	Birth to 6 months: $1,000 6 months to 26 years: Units of $2,500 to $10,000

Please remember to update your beneficiary information whenever there is a family status change.

Note: This is a brief summary of benefits. Please refer to the Evidence of Coverage or Summary Plan Description for a detailed list of the benefits that are covered on this plan.

Disability Benefits (Administered by Cigna) - **NEW!**

Short Term Disability

Short Term Disability (STD)	
Eligibility	A regular employee of the employer working at least 30 hours each week
Weekly Benefit Percentage	66.67%
Maximum Weekly Benefit	$1,846
Minimum Weekly Benefit	$15
Maximum Benefit Period	150 Days
Waiting Period	30 days

Short Term Disability Insurance

- Benefit Waiting period is 30 days for accident, sickness or pregnancy.
- The plan benefit is 66 2/3% to a maximum weekly benefit of $1,846. The benefit will be reduced by Workers' Compensation or any earnings or compensation you are eligible to receive while on STD.
- Maximum Benefit Period is 150 days.
- Twenty-Four hour coverage is provided for both Occupational and Non-Occupational Disabilities.

Note: This is a brief summary of benefits. Please refer to the Evidence of Coverage or Summary Plan Description for a detailed list of the benefits that are covered on this plan.

Disability Benefits (Administered by Cigna) - **NEW!**

Long Term Disability (LTD)	
Eligibility	All active employees of the employer working at least 40 hours each week
Elimination Period	180 Days
Monthly Benefit Percentage	66.67%
Maximum Monthly Benefit	$15,000
Minimum Monthly Benefit	$50
Own Occupation Period	24 Months
Pre-Existing Limitation	3/12

Long Term Disability

- Benefit Waiting Period is 180 days of disability.
- The LTD benefit is 66 2/3% of the first $15,000 of your monthly predisability earnings reduced by deductible income. $15,000 is the maximum monthly benefit. The monthly benefit is reduced by Workers Compensation, PERS, Social Security, and other income sources.
- Once approved, benefits are payable each month while you are disabled up to age 65. This benefit is graded if disabled after age 62.
- A three month survivor benefit is payable to a surviving spouse/domestic partner or child, if you died while receiving benefits.
- Partial Disability is allowed during both the benefit waiting period and while benefits are payable.
- Mental/Nervous, Substance Abuse and Other Limited Condition Disabilities are covered for 24 months during your lifetime.
- A pre-existing condition exclusion with a 90 day pre-existing condition period 12 month exclusion period is included.
- Conversion of Insurance is included.

Note: This is a brief summary of benefits. Please refer to the Evidence of Coverage or Summary Plan Description for a detailed list of the benefits that are covered on this plan.

Employee Assistance Program (Administered by Beacon Health, formerly Value Options)

The Employee Assistance Program (EAP) is designed to help with short-term counseling needs. It offers quick and easy access to confidential, professional assistance and resources to help you and your family address difficulties related to emotional concerns, relationships, substance abuse, legal and financial concerns.

All services are confidential and in accordance with professional ethics and Federal and state laws. Use of the EAP is strictly voluntary.

Additional Benefits:

- Video Counseling is now available in addition to face-to-face and unlimited telephonic sessions, 1-3 sessions per member per issue/year as of 1/1/16.
- Employee Services also include "Daily Living" referrals such as pet sitters, apartment rentals, relocation support, caterers, travel information, wedding planners, etc.

The EAP can support you with:

- Marriage and relationship issues
- Stress management
- Parenting skills
- Alcohol and/or drug abuse
- Finding work/life balance
- Depression and anxiety
- Work-related concerns
- Improving your self-esteem
- Financial or legal concerns
- Finding care for an aging parent
- Personal growth and development
- Living healthier

Visit the Achieve Solutions website any time of day at home or on the go at: www.myachieve.com and read articles, take quizzes, view videos, trainings, audio clips, and workbooks.

EAP services are accessible 24-hours a day , 7 days a week.
Toll-free (800) 662-7241 or online at www.myachieve.com.

Flexible Spending Account (Administered by EBS)

The Flexible Spending Accounts (FSA) are a great way to use pre-tax dollars to pay for expenses paid with after-tax dollars! You may enroll in either or both the Healthcare Spending Account or the Dependent Care Spending Account. These accounts allow you to redirect a portion of your salary on a pre-tax basis into reimbursement accounts. Money from these accounts is then used to pay eligible expenses that are not reimbursed by your health plans, as well as reimbursement for dependent care expenses.

Pre-tax means the dollars you allocate toward these accounts are not subject to social security tax, Federal income tax and, in most cases, state and local taxes. The money you set aside may be used for qualified eligible expenses on a pre-tax basis.

At enrollment, you determine the amount of money to contribute to one or both of these accounts for the City's plan year. The contributions are deducted pre-tax from your paycheck per pay period and deposited into your FSA account(s). You request reimbursement of qualified expenses from your FSA account(s) as you incur the expenses

Healthcare Spending Account

The maximum amount you may contribute to the Healthcare Spending Account for the Plan Year is **$2,550**. This account will reimburse you with pre-tax dollars for qualified out-of-pocket healthcare expenses not covered under your family's healthcare plans. The "Use it or Lose it" rule applies if you do not incur expenses by December 31, 2016 of the plan year following your contributions, you lose the unexpended portion.

Medical-related expenses include out of pocket money for copays or deductibles for medical, dental and vision services. A detailed listing of all qualified expenses are available on the EBS website at ebsbenefits.com.

Note: FSA elections are not automatic. You must re-enroll during Open Enrollment to participate in the FSA for the 2016 plan year.

USE IT OR LOSE IT!

Please estimate your annual contributions carefully! If you don't use all the money in your account by December 31st, 2016 you will forfeit funds left in the account. Participants will have until March 31st of the following plan year to submit claims for expenses incurred during eligible plan year.

Flexible Spending Account (Administered by EBS)

Dependent Care Spending Account

The maximum amount you may contribute to the Dependent Care Spending Account is $5,000 each calendar year, or **$2,500** each calendar year if you are married but file separate tax returns. This account will reimburse you with pre-tax dollars for daycare expenses for your child(ren) and other qualifying dependents. These include expenses for child care or dependent adult care for a member of your household.

Eligible Dependents Include:

- Children under the age of 13 who qualify as dependents on your Federal tax return; and
- Children or other dependents of any age who are physically or mentally unable to care for themselves and who qualify as dependents on your Federal tax return. You may use the Federal childcare tax credit and the Dependent Care Spending Account; however, your Federal credit will be offset by any amount deferred into dependent care plan.

Note: FSA elections are not automatic. You must re-enroll during Open Enrollment to participate in the FSA for the 2016 plan year.

USE IT OR LOSE IT!

Please estimate your annual contributions carefully! If you don't use all the money in your account by December 31st, 2016 you will forfeit funds left in the account. Participants will have until March 31st of the following plan year to submit claims for expenses incurred during eligible plan year.

Required Federal Notices

Notice of Availability of HIPAA Privacy Notice

The Federal Health Insurance Portability and Accountability Act (HIPAA) requires that we periodically remind you of your right to receive a copy of the Insurance Carriers' HIPAA Privacy Notices. You can request copies of the Privacy Notices by contacting the Human Resources Department or by contacting the insurance carriers directly.

The Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires employer groups to notify participants and beneficiaries of the group health plan, of their rights to mastectomy benefits under the plan. Participants and beneficiaries have rights for coverage to be provided in a manner determined in consultation with the attending Physician for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the same deductible and co-payments applicable to other medical and surgical procedures provided under this plan. You can contact your health plan's Member Services for more information.

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits please contact your Human Resources department.

Required Federal Notices (cont.)

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

The federal health care reform law requires that eligible members of an employer plan receive a Summary of Benefits and Coverage (SBC) for any medical and pharmacy plans available. The SBC is intended to provide important plan information to individuals, such as common benefit scenarios and definitions for frequently used terms. The SBC is intended to serve as an easy-to-read, informative summary of benefits available under a plan.

Notice of Choice of Providers

HMO plans generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in their network and who is available to accept you or your family members. Until you make this designation, your carrier will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your insurance carrier directly.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR MEDICAL/HEALTH PLAN COVERAGE

If you decline enrollment in a health plan for your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in a health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in a health plan if your dependent becomes eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment rights, you may add the dependent to your current coverage or change to another health plan.

Required Federal Notices (continued)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**GEORGIA** – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	**INDIANA**– Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	**IOWA** – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS** – Medicaid
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884

Required Federal Notices (continued)

KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK** – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA** – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	**OKLAHOMA** – Medicaid and CHIP
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON** – Medicaid
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA** – Medicaid
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dhs.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	RHODE ISLAND – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300

Required Federal Notices (cont.)

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

SOUTH CAROLINA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/ index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN** – Medicaid and CHIP
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING** – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

Important Notice About Your Prescription Drug Coverage and Medicare
Applies only if you have a Medicare Eligible Dependent

Medicare Part D (Prescription Drug) through CalPERS

Medicare Part D is a voluntary federal outpatient prescription drug benefit available to everyone with Medicare. The Medicare Part D premium varies based on the prescription drug plan and is paid to your health carrier as part of the CalPERS health premium. As with Medicare Part B, if your income exceeds established thresholds, the SSA will assess an additional income-related monthly adjustment amount. Payment of this amount is mandatory to protect your Medicare enrollment and eligibility to remain enrolled in a CalPERS Medicare health plan.

To be enrolled in a CalPERS Medicare health plan, you cannot be enrolled in a non-CalPERS Medicare Part D plan.

CalPERS Health Plans and Medicare Part D
CalPERS participates in the Employer Group Waiver Plan (EGWP). EGWPs are Prescription Drug Plans governed by the CMS.

If you are a Medicare-eligible subscriber or dependent, you are automatically enrolled into EGWP. If for some reason, you chose to opt out of EGWP, you will be financially responsible for all of your prescription drug costs. In addition, if you enroll in a non-CalPERS Medicare Part D plan, you are no longer eligible to remain enrolled in a CalPERS Medicare health plan. Consequently, you and all of your covered dependents will be terminated.

Contact the City of Newport Beach Human Resources Department for more details.

Do Not Enroll in a non-CalPERS Medicare Part D Plan

Your CalPERS coverage includes enrollment in a Medicare Part D Plan. Do not enroll in a non-CalPERS Medicare Part D plan. If you or your dependents are covered by CalPERS and another health plan that includes Medicare Part D prescription drug benefits, you must cancel that Part D coverage to enroll in, or continue enrollment in a CalPERS Medicare health plan.

Important Notice About Your Prescription Drug Coverage and Medicare
Applies only if you have a Medicare Eligible Dependent

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The City of Newport Beach and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

- The City has determined that the prescription drug coverage offered by the City of Newport Beach is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you do decide to join a Medicare drug plan and drop your current City prescription drug coverage, be aware that you and your dependents will may not be able to get this coverage back.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with The City of Newport Beach and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

Continued...

Important Notice About Your Prescription Drug Coverage and Medicare
Applies only if you have a Medicare Eligible Dependent

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the City of Newport Beach Human Resources Department.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2016
Name of Entity:	City of Newport Beach
Contact:	Human Resources
Address:	100 Civic Center Drive, Newport Beach, CA 92660
Phone:	(949) 644-3300

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Contact Information

Anthem Blue Cross Select and Traditional HMO		Health Net HMO	
Member Services Website	(855) 839-4524 www.anthem.com/ca/calpers/hmo	Member Services Website	(888) 926-4921 www.healthnet.com/calpers
Blue Shield Access+ and NetValue HMO		**Sharp HMO**	
Member Services Website	(800) 334-5847 www.blueshieldca.com/calpers	Member Services Website	(855) 995-5004 www.sharphealthplan.com/calpers
Kaiser Permanente HMO		**Cigna (Basic Life/AD&D, Vol Life/AD&D, LTD & STD)**	
Member Services Website	(800) 464-4000 www.kp.org/ca/calpers	Member Services Website	(800) 362-4462 www.mycigna.com
UnitedHealthcare Alliance HMO		**MES Vision**	
Member Services Website	(877) 359-3714 www.uhc.com/calpers	Member Services Website	(800) 877-6372 www.mesvision.com
Anthem Blue Cross PPO		**Beacon Health (EAP)**	
Member Services Website	(877) 737-7776 www.anthem.com/ca/calpers	Member Services Website	(800) 662-7241 www.myachieve.com
Anthem Blue Cross PORAC PPO		**Cigna Dental PPO & DHMO**	
Member Services Website	(800) 288-6928 www.porac.org	Member Services Website	(800) 244-6224 www.mycigna.com

Employee Benefits Overview designed and developed by

Alliant EMPLOYEE BENEFITS

in conjunction with the City of Newport Beach,